UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

FOUR WOMEN HEALTH SERVICES, LLC, Plaintiff, v. ABUNDANT HOPE PREGNANCY RESOURCE CENTER INC., d/b/a ATTLEBORO WOMEN'S HEALTH CENTER, CATHERINE ROMAN, NICOLE CARGES, and, DARLENE HOWARD, Defendants.	Civil Action No. 24-12283

COMPLAINT AND JURY DEMAND

INTRODUCTION

1. Plaintiff Four Women Health Services, LLC ("Four Women") brings this action against Defendant Abundant Hope Pregnancy Resource Center Inc. d/b/a Attleboro Women's Health Center ("AWHC"), Catherine Roman, Nicole Carges, and Darlene Howard (collectively, "Defendants") to halt Defendants' unlawful practices of interfering with women seeking to obtain reproductive healthcare services at Four Women.

2. "Access to reproductive health care services . . . is a right secured by the constitution and laws of the commonwealth." M.G.L. ch. 12, § 11I 1/2. Defendants actively manipulate the lawful reproductive healthcare marketplace to deprive women of this right.

3. Interfering with women's access to reproductive healthcare is not new. Women seeking reproductive healthcare have faced intimidation, obstruction, and other forms of interference for decades. Since 1994, the Freedom of Access to Clinic Entrances Act ("FACE Act"), 18 U.S.C. § 248, has helped shield many women from such conduct—but it has led some organizations to pursue more sophisticated interference strategies.

4. AWHC is an organization whose mission is to prevent women from obtaining reproductive healthcare services, especially abortion care. In furtherance of this mission, it engages in false advertising, deception, and recently, technological attacks to redirect patients from Four Women to AWHC and prevent them from receiving their chosen and preferred reproductive healthcare services.

5. Defendants' false advertising and deception begins with AWHC's marketing. Its anodyne name and website contents, including prompts to make appointments in connection with abortion care, are designed to deceive women into believing AWHC is a licensed medical provider.

6. AWHC is not a licensed medical facility. It cannot lawfully provide ultrasounds, gynecological care, or any of the other medical services it advertises on its website.

7. Recently, Defendants have employed more advanced technological methods to specifically target Four Women patients. Four Women has learned of multiple cases in which AWHC has intercepted communications between Four Women and patients[1] scheduling appointments. Within minutes of communicating with Four Women, the patients received a call on their cell phone from AWHC. These Four Women patients had never called or contacted AWHC; AWHC's outreach arose only after the women contacted Four Women.

8. Once on the phone, AWHC employed several strategies to prevent the women from showing up to their Four Women appointments: In some cases AWHC indicated that it *was* Four Women, to hijack the potential appointment or cause the patient to believe her Four Women appointment had been canceled; and in others it suggested it was affiliated with Four Women, falsely instructing the woman she must receive an ultrasound at AWHC before her Four Women procedure, in an attempt to derail the woman's pursuit of services from Four Women.

[1] This Complaint refers to "patients" herein to encompass both existing Four Women patients and prospective patients.

9. AWHC's unlawful outreach to Four Women's patients appears to be the result of Defendants' infiltration of Four Women's electronic platforms. AWHC intercepts messages sent by women seeking reproductive healthcare services from Four Women with a goal of disrupting the process and misdirecting them to prevent Four Women patients or potential patients from receiving the reproductive healthcare services they seek.

10. Once onsite, AWHC's scheme to obstruct Four Women patients' access to Four Women involves a combination of deceptive maneuvers. AWHC's physical location alone is designed to deceive Four Women patients into inadvertently entering AWHC—in 2018, after much effort, AWHC moved essentially next-door to Four Women. Once inside, AWHC often coerces women who enter to prevent or delay their departure, including by instructing them they must receive certain care at AWHC (such as ultrasounds) prior to their Four Women appointments. AWHC then purports to perform medical services for these women, despite lacking the requisite license to do so, and the medical "advice" it provides is often dangerously inaccurate.

11. At minimum, AWHC's conduct delays and frustrates women seeking care from Four Women by an hour or two. Four Women is aware of several instances in which women eventually returned to Four Women and were able to access care, but days later than intended.

12. When it comes to reproductive healthcare, several days of delay may make all the difference in a woman's health or the care she can safely receive. Four Women can only imagine how many women have been deterred or blocked from receiving any care from Four Women as a result of AWHC's deception, or how many women AWHC has placed at risk through its illegal and dangerous medical advice.

13. Four Women brings this action to prevent Defendants from continuing to interfere with women's access to reproductive healthcare through these unlawful means.

PARTIES

14. Plaintiff Four Women is a Massachusetts limited liability company organized under the laws of Massachusetts and with a principal place of business in Attleboro, Massachusetts.

15. Defendant AWHC is a nonprofit corporation organized under the laws of Massachusetts in 2010 under the name the Attleboro Women's Center Incorporated. On January 25, 2011, the Attleboro Women's Center Incorporated changed its name to Abundant Hope Pregnancy Resource Center Inc. ("Abundant Hope"). It maintains a principal place of business in Attleboro, Massachusetts, and does business under the name Attleboro Women's Health Center.

16. Defendant Catherine Roman is the President of Abundant Hope and resides in North Attleboro, Massachusetts 02760.

17. Defendant Nicole Carges is the Treasurer of Abundant Hope and resides in North Attleboro, Massachusetts 02760.

18. Defendant Darlene Howard is the Executive Director of Abundant Hope and resides in Mansfield, Massachusetts 02048.

19. At all relevant times Defendants Roman, Carges, and Howard have controlled and directed the actions of AWHC.

JURISDICTION

20. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 because this action includes claims arising under the laws of the United States, specifically the U.S. Computer Fraud & Abuse Act ("CFAA"), 18 U.S.C. § 1030, *et seq.*; and Title I of the Electronic Communications Privacy Act of 1986, 18 U.S.C. § 2510, *et seq.* ("Federal Wiretap Act"). The Court has supplemental jurisdiction over the state law claims herein pursuant to 28 U.S.C. § 1367 because the claims are so related to the federal claims for which this Court has original jurisdiction that they form part of the same controversy.

21. This Court has personal jurisdiction over Defendants because AWHC has a principal place of business in the Commonwealth of Massachusetts and Defendants Roman, Carges, and Howard reside and are domiciled in the Commonwealth of Massachusetts.

22. Venue is proper in this district pursuant to 28 U.S.C. § 1391 (b)(1) and (2) because Defendants reside in the District of Massachusetts and the events giving rise to the claims in this action occurred in substantial part within this District.

FACTS

I. Four Women Provides Legal Reproductive Healthcare to Women Who Seek It.

23. Four Women is licensed with the Massachusetts Department of Public Health as a clinic and ambulatory surgical center that provides comprehensive gynecological care.

24. Founded in 1998 to ensure that all women have access to high quality reproductive healthcare, Four Women serves communities that often lack access to care—especially low-income communities. It is one of only three reproductive healthcare clinics that provide abortion care in southeastern Massachusetts, and the only one offering surgical abortion services. Since April 2003, Four Women has maintained a fully licensed surgery center with experienced staff, including licensed medical doctors, nurses, and medical assistants.

25. Four Women provides a range of reproductive healthcare services, including birth control information and prescriptions, ultrasounds, abortion care, and more. As Four Women is a for-profit entity, they charge for their services, accepting health insurance and direct payments from patients.

II. AWHC Is Not a Licensed Medical Facility in the Commonwealth.

26. AWHC is not licensed by the Massachusetts Department of Public Health to provide medical care.

27. Massachusetts law requires clinics, which include "any entity, however organized, whether conducted for profit or not for profit, that is advertised, announced, established, or maintained for the purpose of providing ambulatory medical . . . services," to be licensed by the Department of Public Health.[2] "Ambulatory medical services are services providing diagnosis or treatment of a health condition and include procedures such as diagnosing pregnancies, performing ultrasounds and other clinical procedures."[3]

28. AWHC purports to provide ambulatory medical services, including diagnosing pregnancies and performing ultrasounds.

29. Providing diagnosis regarding viability and location of the fetus without the assistance of a licensed doctor or Advanced Practice Registered Nurse is a violation of Massachusetts regulations pertaining to the practice of medicine and nursing.

30. Upon information and belief, AWHC staff that is not licensed to diagnose a pregnancy conveys a diagnosis prior to the participation of medical staff licensed to do so.

31. AWHC is organized as a nonprofit and purports to provide medical services to patients at no cost. The individual defendants play a leadership role in developing and executing its mission as well as fundraising.

32. AWHC has attempted to use the legal system to intimidate Four Women. For example, on June 22, 2022, AWHC sent Four Women a letter threatening a lawsuit under Massachusetts General Laws ch. 93A, § 11. The accusations in the letter were baseless, as Four

[2] *Reminder to Licensees Regarding Licensure Obligations and Providing Standard of Care*, Robert Goldstein, MD, PhD, Commissioner, Department of Public Health Executive Office of Health and Human Services for the Commonwealth of Massachusetts, 1 (Jan. 3, 2024), *available at* https://www.mass.gov/doc/reminder-to-licensees-regarding-licensure-obligations-and-providing-standard-of-care-january-3-2024/download (citing M.G.L. c. 111, § 51).
[3] *Id.*

Women stated in its letter in response. True and accurate copies of both letters are attached hereto as **Exhibit A**.

III. AWHC Works to Interfere with the Reproductive Healthcare Services Marketplace Through False and Deceptive Advertising.

33. AWHC's primary mission is to inject itself into the reproductive healthcare marketplace to prevent women from accessing all legally protected reproductive healthcare, with a specific focus on preventing women from accessing abortion care.

34. AWHC purports to provide reproductive healthcare services.

35. AWHC advertises on its website that it provides "medical appointments" and "medical tests."[4]

36. Defendants proclaim that they have performed hundreds of "medical appointments" and "medical tests," at the monetary value of $157,000 in 2023 alone.[5]

37. Defendants tout these medical "services," including how they interfere with women accessing Four Women, in connection with efforts to raise funds from donors for their work manipulating the reproductive healthcare marketplace.

38. AWHC advertises, including through the purchase of Google advertising, that it provides medical services to women including pregnancy testing, ultrasounds, pregnancy consultation, and testing for sexually transmitted diseases.[6]

39. AWHC advertises that its ultrasounds identify (1) the gestational age of a fetus; (2) the location of the pregnancy, by determining whether the pregnancy is intrauterine or ectopic—

[4] *See* "About," Attleboro Women's Health Center, https://awhc.net/services/ (last visited Aug. 21, 2024).
[5] *See* "About Us," Abundant Hope Pregnancy Resource Center, https://www.ahprc.org/about/ (last visited Aug. 28, 2024).
[6] *See* "Services," Attleboro Women's Health Center, https://awhc.net/services/ (last visited Aug. 13, 2024).

meaning outside the uterus and not viable; and (3) any cardiac activity, which "can verify that the fetus is viable."[7]

40. According to the American College of Obstetricians and Gynecologists, "[t]he concept of viability of a fetus is frequently misrepresented or misinterpreted based on ideological principles."[8] The term has two meanings: "In the first, 'viability' addresses whether a pregnancy is expected to continue developing normally. In early pregnancy, a normally developing pregnancy would be deemed viable, whereas early pregnancy loss or miscarriage would not. In the second, 'viability' addresses whether a fetus might survive outside of the uterus. Later in pregnancy, a clinician may use the term 'viable' to indicate the chance for survival that a fetus has if delivered before it can fully develop in the uterus."[9]

41. It is the latter form of "viability" that has been used in connection with abortion care from a legal standpoint, as many state laws (such as Massachusetts) prohibit abortion after a fetal gestational age (typically between 24 and 26 weeks) that is widely considered "fetal viability."

42. The first definition of "viability" has no connection with abortion care. There is no scientific or legal basis to restrict a woman's access to abortion care based on whether her early pregnancy is developing normally.

43. AWHC misuses the term "viability" to confuse and mislead women seeking abortion care.

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[7] *See* "Ultrasounds," Attleboro Women's Health Center, https://awhc.net/services/ultrasounds/ (last visited Aug. 13, 2024).

[8] *See* "Facts Are Important: Understanding and Navigating Viability," https://www.acog.org/advocacy/facts-are-important/understanding-and-navigating-viability (last visited Aug. 31, 2024).

[9] *Id.*

44. For example, AWHC's website contains a page titled "Thinking About Abortion?" which instructs women seeking abortions to first "confirm" their pregnancy with an ultrasound, stating: "Even if you've taken a home pregnancy test, you need more information. It's critical to confirm that your pregnancy is viable (growing inside the uterus with a detectable heartbeat) with an ultrasound."

45. Invoking "viability" is calculated to deceive women seeking abortion care to delay them beyond the recommended time for a medication abortion, which is ordinarily limited to the first 10 weeks of pregnancy.[10]

46. AWHC's guidance on "viability" also includes dangerous misinformation about ectopic pregnancies.

47. On the same page of AWHC's website, below the heading "Why Is It Important To Confirm Your Pregnancy If You Want An Abortion?", AWHC states that ectopic pregnancies or active sexually transmitted infections can cause life-threatening outcomes.

48. AWHC also counsels women through distributed printed materials that "[y]ou may have a serious ectopic pregnancy and abortion is dangerous."[11]

49. These materials convey the message that it would be unsafe for women with ectopic pregnancies to receive abortions. This advice is more than false; it puts women at grave risk.

50. In fact, failure to terminate an ectopic pregnancy can cause serious bodily harm or death. According to the American College of Obstetricians and Gynecologists, "ectopic

[10] Medication abortion mifepristone is safe through 70 days (10 weeks) of pregnancy. *See* "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation," U.S. Food and Drug Administration, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation, (last visited August 31, 2024).

[11] Heartbeat International provides propaganda to AWHC, including a pamphlet deceiving women about ectopic pregnancies. *See* **Exhibit B**.

pregnancies will never be viable, and the treatment for ectopic pregnancy requires ending the nonviable pregnancy."[12] Even with proper diagnosis and management, "ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity" and is "the leading cause of hemorrhage-related mortality." **Exhibit C**.

51. AWHC's preventing women from terminating ectopic pregnancies can therefore cause grave, even fatal harm to the women.

IV. AWHC Specifically Directs Its Deception Toward Women Seeking Services from Four Women.

52. In or around May 2018, AWHC attempted to move into the same address as Four Women, 150 Emory Street.

53. When this failed, AWHC moved its principal office to 152 Emory Street directly next to Four Women.

54. 150 Emory Street and 152 Emory Street share a driveway and parking lot.

55. AWHC leverages its physical proximity in its tactics to both insert itself into the reproductive healthcare marketplace and target women intending to access reproductive healthcare services from Four Women.

56. First, women seeking reproductive healthcare services occasionally make appointments with AWHC, believing they are making appointments at Four Women.

57. Prospective patients, perhaps aware that the only abortion care provider in the region is in Attleboro, Massachusetts, are reasonably misled by AWHC's name and website to believe that AWHC provides such services. For example:

- AWHC's website contains a page titled "Options," of which the first "option" listed is

[12] *See* "Facts Are Important: Understanding and Navigating Viability," https://www.acog.org/advocacy/facts-are-important/understanding-and-navigating-viability (last visited, August 31, 2024).

abortion.[13]

- AWHC's website contains a page titled "Abortion," and lists questions women may have "about the abortion pill and other abortion procedures," and directs women who are "thinking about abortion" to make an appointment with a button highlighted in green, stating "MAKE AN APPOINTMENT."[14]
- The page also contains quotes purporting to be a testimonial regarding AWHC's services, which states: "Great place for women considering abortion. Staff is friendly and nonjudgmental."

58. When women contact AWHC seeking abortion care, they are not informed that AWHC does not provide abortion care; they are instead given appointments at AWHC.

59. Then, Defendants interfere with women's physical access to Four Women.

60. Individuals acting on behalf of Defendants obstruct Four Women's main driveway by pacing with placards at the entrance. Ride-sharing drivers often refuse to enter Four Women's parking lot due to the conduct of the individuals with the placards, instead dropping patients in the street where AWHC can engage and interfere with them. This interference includes, but is not limited to, AWHC approaching patients to attempt to give them literature and other information.

61. To assist patients in overcoming AWHC's interference, Four Women relies on volunteers, who wear colored and labeled parking vests to protect patient access and escort them to the facility.

62. Individuals acting on behalf of AWHC, however, often wear vests to appear as Four Women volunteers and confuse and deceive the patients.

[13] "Options," Attleboro Women's Health Center, https://awhc.net/options/ (last visited Aug. 13, 2024).

63. In addition, when women inadvertently enter AWHC for their Four Women appointments, they are not informed that they are in the wrong place.

64. Instead, AWHC engages in conduct to prevent women from leaving its premises, including conducting lengthy intake procedures; obtaining, holding, and copying personal identification cards; sequestering women in isolated rooms; and conducting tests appearing to be ultrasounds.

65. AWHC's presentation of its staff as medical—although by information and belief they are unlicensed—is coercive. Women held in isolation rooms under the auspices of receiving testing or "counseling" necessary for medical treatment often do not feel free to leave the premises or refuse to comply with what they are led to believe are medical instructions.

66. As an example, in or around March of 2024, Jane Doe 1 undertook efforts to seek reproductive healthcare, specifically a medication abortion.[15]

67. Through its online advertising, AWHC led Jane Doe 1 to believe that AWHC was the Attleboro clinic that provided abortions—*i.e.*, that AWHC was Four Women.

68. Jane Doe 1's support person called AWHC on her behalf to schedule an appointment for a medication abortion, and AWHC—rather than stating that they do not provide such care—made an appointment for her. Accordingly, AWHC led Jane Doe 1 to believe that her AWHC appointment was for the medication abortion services she sought.

69. Jane Doe 1 brought cash with her to the appointment as she was prepared to pay for the reproductive healthcare services. Upon arrival at her appointment, AWHC requested Jane Doe

[15] Four Women patients are referred to herein using pseudonyms. *See Doe v. Bell Atl. Bus. Sys. Servs., Inc.*, 162 F.R.D. 418, 420 (D. Mass. 1995) (courts permit the utilization of pseudonyms for parties "in cases involving social stigmatization [or] real danger of physical harm . . . . Cases in which parties are allowed to proceed anonymously because of privacy interests often involve abortion.").

1's identification and informed her that they accepted health insurance, so the cash was not necessary.

70. AWHC then brought Jane Doe 1 to a room away from the waiting room with only one door, no windows, and no phone.

71. Jane Doe 1 was accompanied to AWHC by a support person, but Jane Doe 1 was sequestered in this room alone with AWHC staff.

72. AWHC kept Jane Doe 1 in this sequestration room for more than an hour, during which time AWHC staff provided medically inaccurate information regarding abortions.

73. AWHC misled Jane Doe 1 to believe that this consultation was a required step in the process for undergoing an abortion and, therefore, that she could not leave if she wanted to obtain the services she sought.

74. AWHC staff then brought Jane Doe 1 to another room where three employees—including one self-identified ultrasound technician and one self-identified Registered Nurse—purported to perform an ultrasound.

75. There was no doctor present at any point during Jane Doe 1's experience at AWHC.

76. The AWHC staff told Jane Doe 1 that no heartbeat could be detected but provided ultrasound images to her purportedly stating the gestational age of her fetus. Using this information, they informed her that she could not undergo an abortion at that time as she was only six weeks pregnant.

77. Jane Doe 1 requested to still undergo the medication abortion, but AWHC instructed her that in order to do so she would need to return in two weeks for another ultrasound.

78. Jane Doe 1 believes she was ten weeks pregnant at the time.

79. AWHC's behavior during Jane Doe 1's visit was designed to mislead Jane Doe 1 and delay and even—by providing false medical advice, causing her to endure a difficult appointment, misdiagnosing her pregnancy, and ultimately declining her the treatment she sought—prevent her from obtaining abortion care services from Four Women.

80. Following her AWHC appointment, Jane Doe 1 scheduled an appointment with Four Women.

81. A few days later, Jane Doe 1 attended her appointment with Four Women. While she was actually inside Four Women's office for that appointment, AWHC called Jane Doe 1 on her cell phone. Jane Doe 1, unaware that the caller was AWHC, answered the call. The AWHC speaker asked Jane Doe 1 about her plans with respect to her pregnancy. Jane Doe 1 realized the speaker was AWHC and hung up the call.

82. While she was on this call, Jane Doe 1's support person noticed an individual circling the Four Women facility. Jane Doe 1 believes this person was affiliated with AWHC, conducting surveillance, and had seen her enter Four Women.

83. AWHC's actions, including holding Jane Doe 1 in isolated areas she did not feel free to leave, calling her during her Four Women appointment, and appearing to surveil the Four Women facility, placed Jane Doe 1 in apprehension and fear. Indeed, while she still seeks reproductive healthcare from Four Women, including birth control, she does not go physically to the facility out of fear of what AWHC had already done and might attempt to do next.

84. Jane Doe 1's experience and her resulting trauma is not unique: Four Women staff frequently hear from women they treat that AWHC has attempted to interfere with their access to Four Women or deceived them about the reproductive healthcare services marketplace.

85. For example, on or around October 25, 2023, Jane Doe 2 had an appointment at Four Women, but because of AWHC's deceptive in-person tactics, she inadvertently went into AWHC's facility. AWHC led Jane Doe 2 to believe that AWHC was Four Women, putting her through their intake process and leading her to a sequestration room. While in the sequestration room, AWHC staff attempted to dissuade Jane Doe 2 from her intended healthcare decisions (terminating her pregnancy), and shamed her for that decision.

86. Jane Doe 3 and Jane Doe 4 also both had appointments with Four Women but inadvertently ended up in AWHC due to in-person misdirection.

87. In October 2023, upon arrival at AWHC, Jane Doe 3 stated that she had an appointment. AWHC knew Jane Doe 3 did not have an appointment at AWHC, but staff did not inform her until she had checked in and provided her identification, which AWHC copied, that she was in the wrong place.

88. In November 2023, Jane Doe 4 arrived at AWHC for a Four Women appointment. She told AWHC she had an appointment—AWHC knew Jane Doe 4 did not have an appointment there but did not inform her until after she spent twenty minutes completing paperwork, copying her identification, and asking her probing questions.

89. AWHC's actions delay and potentially prevent Four Women's patients from accessing Four Women and attending their scheduled appointments at Four Women.

V. AWHC Intercepts Four Women's Confidential Patient-Client Communications and Contacts Patients Directly.

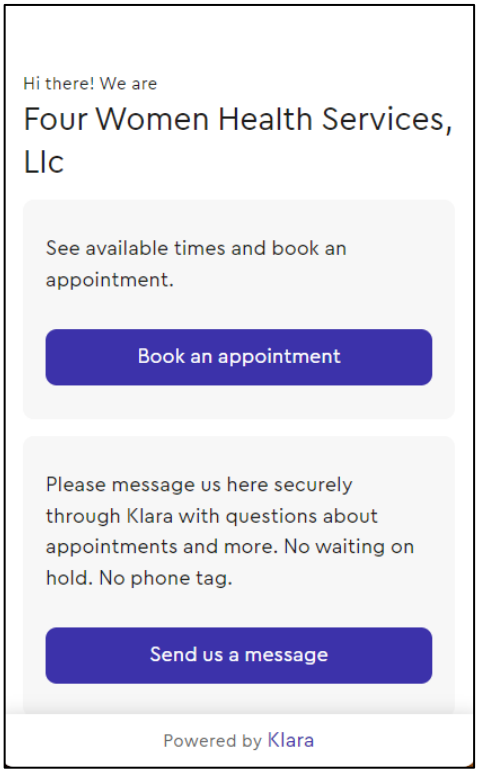
90. Recently, AWHC has realized that they need not simply wait for Four Women patients to see their marketing and come to them. Instead, AWHC has become more proactive, using technology to target women seeking reproductive healthcare services from Four Women and reaching out to them directly.

91. Specifically, on multiple occasions over the past year, AWHC has intercepted electronic communications between patients and Four Women as they are scheduling appointments. Using information gained through this interception, AWHC then called Four Women patients directly on their cell phones.

92. Many patients schedule appointments with Four Women by phone, simply by calling Four Women. Many other patients schedule appointments with Four Women online.

93. Four Women's website contains a widget that permits patients or potential patients to make appointments or send messages to Four Women.

94. The widget connects to a platform managed by Klara Technologies, Inc. ("Klara"), which facilitates secure patient messaging, among other services.



[16]

[16] Screen shot of Four Women Health Services, https://www.fourwomen.com/ (last visited Sep. 1, 2024).

95. When patients select "Send us a message" on the Klara widget, they are prompted to type their message and provide their cell phone number so that Four Women may respond.

96. Four Women staff then responds using the organization's Klara page, which staff can access using a browser on their computer or an application on their mobile device.

97. Messages sent by Four Women staff using the Klara platform are then sent to the inquiring patients on their respective devices.

98. Immediately after booking an appointment, appointment information—including the patient's name, phone number, and appointment type—is uploaded to Athenahealth, Inc. ("Athena"), a third-party electronic health record system.

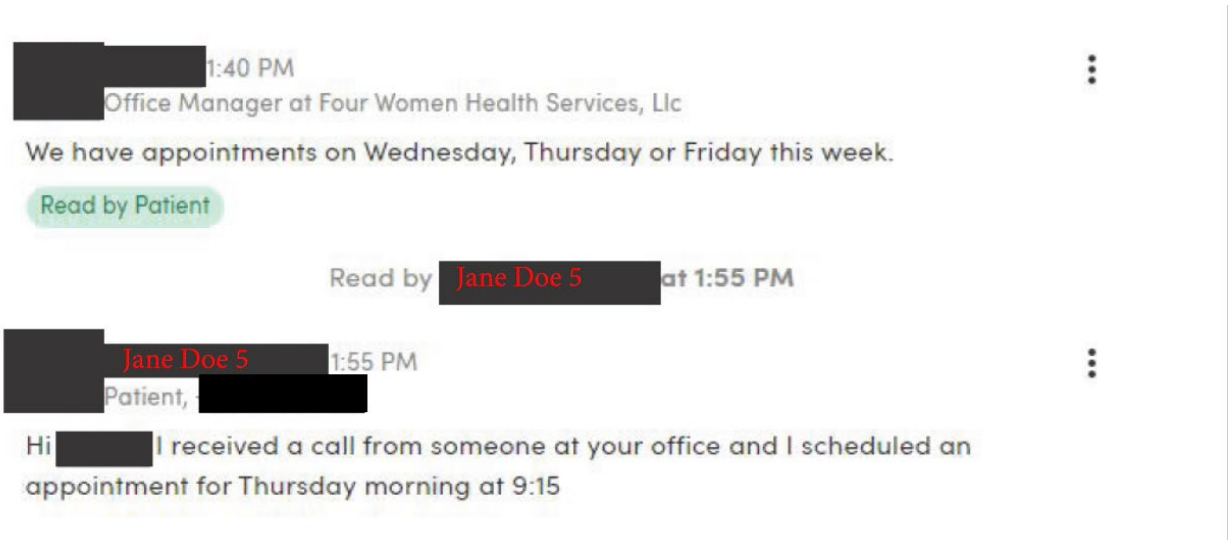
99. Four Women uses Athena to manage patient health records and information. Four Women's Athena platform stores patient records, appointments, and information. Four Women's patient visitation schedule also resides on the Athena platform.

100. Recently, Four Women has learned of multiple instances in which electronic communications with patients sent via Klara were apparently intercepted by AWHC.

101. For example, on or about 1:25 p.m. on October 30, 2023, Jane Doe 5 contacted Four Women seeking to schedule an ultrasound after testing positive on a home pregnancy test.

102. Through electronic messaging facilitated by Klara, Four Women staff communicated with Jane Doe 5 about scheduling an appointment. At 1:40 p.m., Four Women wrote: "We have appointments on Wednesday, Thursday or Friday this week."

103. At 1:55 p.m., Jane Doe 5 responded: "I received a call from someone at your office and I scheduled an appointment for Thursday morning at 9:15."



104. Four Women had not called Jane Doe 5.

105. Four Women informed Jane Doe 5 that no one in the Four Women office had called her, and that Four Women does not see patients on Thursday mornings.

106. Jane Doe 5 received a text confirmation for her Thursday appointment, which stated that the appointment was with AWHC.

107. Jane Doe 5 had never contacted or communicated with AWHC prior to October 30.

108. Jane Doe 5's October 30 messages with Four Women was the only method by which AWHC could have obtained Jane Doe 5's contact information and known that she was pursuing reproductive healthcare services that day. AWHC's interference occurred in real time, offering an appointment on one of the three days identified by Four Women less than 15 minutes prior. Thus, on information and belief, AWHC intercepted Jane Doe 5's communications with Four Women that day and obtained both her cell phone number and the content of the communication.

109. AWHC's practice of calling women who have communicated with Four Women is not isolated to Jane Doe 5.

110. As a further example, Jane Doe 6 scheduled an appointment for a medication abortion with Four Women on or about May 1, 2024. At 9:05 a.m., Jane Doe 6 contacted Four Women to schedule an appointment.

111. Jane Doe 6 and Four Women then messaged using the Klara platform to schedule an appointment. At 10:09 a.m., Four Women sent Jane Doe 6 a link on Klara that she could use to upload insurance information.

112. Two minutes after Four Women's message, AWHC called Jane Doe 6.

113. Specifically, Jane Doe 6 received a call at 10:11 a.m. from the phone number (508) 455-0172.

114. AWHC's phone number is (508) 455-0172.

115. Jane Doe 6 answered the call. During the call, AWHC made misleading statements to indicate it was the entity with which she had made an appointment. AWHC stated it had received her online request for an appointment and that she was required to undergo an ultrasound prior to the medication abortion to verify the pregnancy and see if it is viable.

116. AWHC's statements to Jane Doe 6 contradict medical advice and reproductive healthcare standards of care.

117. AWHC's tactics are not limited to patients seeking abortion care. AWHC also seeks to interfere with women seeking other reproductive healthcare services from Four Women.

118. For example, on or around August 31, 2023, Jane Doe 7 contacted Four Women and scheduled an appointment for birth control.

119. Minutes after booking an appointment with Four Women, Jane Doe 7 received a call from AWHC. During the call, AWHC personnel stated that it could not provide her with birth control and invited her instead to a diaper give-away. AWHC deceived Jane Doe 7 to believe that

she was speaking with Four Women and not AWHC. At the end of the call, Jane Doe 7 believed that her appointment with Four Women had been canceled.

120. Additionally, on or around May 6, 2024, Jane Doe 8 messaged Four Women using its online platform, operated by Klara, and made an appointment for a medication abortion.

121. On the day of her appointment, AWHC called Jane Doe 8 on her cell phone. On the call, AWHC attempted to persuade Jane Doe 8 to come to AWHC before or in lieu of Four Women. Jane Doe 8 had never previously contacted AWHC and does not know how AWHC obtained her contact information.

122. AWHC intercepted Jane Doe 5-8's, phone, online, and/or text communications with Four Women and used it to obtain names, phone numbers, and appointment requests, and ultimately contact the patient with the sole purpose of preventing her from accessing reproductive healthcare at Four Women.

123. Four Women is aware of this interception through women who have informed Four Women of AWHC's conduct. AWHC has likely intercepted countless other women from accessing reproductive healthcare at Four Women. On a regular basis, women who have scheduled appointments through online communications or using the appointments option in the Klara widget cancel or do not show up for their appointments. Four Women thus reasonably believes there are women for whom AWHC's conduct has prevented their access to Four Women altogether.

COUNT I

Violation of the Computer Fraud and Abuse Act, 18 U.S.C. § 1030, *et seq.*

124. Four Women incorporates the allegations contained in Paragraphs 1 - 121 as if fully set forth herein.

125. Four Women brings this action under 18 U.S.C. § 1030(g) allowing any injured person to maintain a civil action against the violator of the CFAA.

126. Four Women's computer system and web-based platforms are a "protected computer" within the meaning of the CFAA because they were used in or affected interstate or foreign commerce or communication and each constitutes an electronic, cloud-based, or other high-speed data processing device performing logical, arithmetic, or storage functions, or a data storage facility or communications facility directly related to or operating in conjunction with such device.

127. Four Women did not authorize AWHC to access its computer system or web-based platforms.

128. AWHC nevertheless accessed Four Women's computer system and/or web-based platforms and obtained information from that system, including the names and contact information of patients or women seeking to make appointments with Four Women.

129. For example, AWHC gained unauthorized access to Four Women's electronic communications with Jane Does 5-8 as they were in the process of or had recently completed communicating with Four Women to schedule appointments.

130. As a consequence of the foregoing, Four Women has suffered and will continue to suffer irreparable harm.

131. By engaging in the foregoing conduct, AWHC violated 18 U.S.C. § 1030(a)(2)(C).

132. AWHC's unauthorized access to Four Women's computer system resulted in the modification or impairment, or potential modification or impairment, of the medical examination, diagnosis, treatment, or care of one or more Four Women patients.

133. AWHC's unauthorized access to Four Women's computer system resulted in Four Women accruing costs responding to the offense and lost revenue and other consequential damages exceeding $5,000.

134. A violation of 18 U.S.C. § 1030(a)(2)(C) that results in the modification or impairment, or potential modification or impairment, of the medical examination, diagnosis, treatment, or care of one or more individuals entitles Four Women to injunctive relief. 18 U.S.C. § 1030(g).

COUNT II

Violation of the Federal Wiretap Act, 18 U.S.C. § 2510, *et seq.*

135. Four Women incorporates the allegations contained in Paragraphs 1 - 132 as if fully set forth herein.

136. Four Women brings this action under 18 U.S.C. § 2511(1)(a), allowing any injured person to maintain a civil action against the violator of the Federal Wiretap Act.

137. AWHC intended to intercept communications between Four Women and potential or existing Four Women patients.

138. AWHC intercepted electronic and/or telephonic communications between Four Women and women seeking appointments or services with Four Women, including between patients' cell phones and Four Women's account on the Klara online platform.

139. AWHC's interception of Four Women's electronic and/or telephonic communications was contemporaneous with the communications as they were made: For example, AWHC called Jane Doe 5 as she was in the course of messaging Four Women to make her appointment and called Jane Doe 6 within minutes of making her appointment and messaging with Four Women online. Jane Doe 7 received a call on her cell phone from AWHC minutes after making an appointment with Four Women.

140. AWHC's interception of communications included such content as patient names, phone numbers, and the patients' requests for appointments with Four Women.

141. AWHC intercepted electronic and/or telephonic communications made by Four Women using its own electronic devices, including its web server, to gain unauthorized access to Four Women's electronic and/or telephonic messages, including its Klara account.

142. AWHC's conduct has caused irreparable harm to Four Women and the patients pursuing care with Four Women.

143. A violation of 18 U.S.C. § 2511(1)(a) entitles Four Women to injunctive relief, statutory damages of $100 a day for each day of violation or $10,000, whichever is greater, and reasonable attorney's fees and costs. 18 U.S.C § 2520(a)-(c).

COUNT III

Violation of the Massachusetts Wiretap Act, M.G.L. c. 272, § 99

144. Four Women incorporates the allegations contained in Paragraphs 1 - 141 as if fully set forth herein.

145. Four Women brings this action under M.G.L. c. 272, § 99 ("Massachusetts Wiretap Act"), allowing any injured person to maintain a civil action against the violator of the Massachusetts Wiretap Act.

146. Four Women engaged in wire communications when it messaged with Four Women patients and scheduled appointments with Four Women patients electronically or telephonically, including via the Klara platform.

147. The contents of Four Women's wire communications were intercepted when AWHC secretly recorded them by copying down patient names, phone numbers, and the patients' requests for appointments with Four Women.

148. AWHC intercepted communications made by Four Women using its own intercepting devices, including its web server, to gain unauthorized access to Four Women's electronic and/or telephonic messages, including its Klara account.

149. AWHC's conduct has caused irreparable harm to Four Women and the patients pursuing care with Four Women.

150. AWHC's willful violation of M.G.L. c. 272, § 99 entitles Four Women to injunctive relief, statutory damages computed at the rate of $100 per day for each day of violation or $1,000, whichever is greater, and reasonable attorney's fees and costs. M.G.L. c. 272, § 99.

COUNT IV

Violation of Massachusetts Consumer Protection Act M.G.L. c. 93A, § 1, *et seq.*

151. Four Women incorporates the allegations contained in Paragraphs 1 - 148 as if fully set forth herein.

152. AWHC through its actions and advertising have engaged in unfair competition and deceptive acts in order to manipulate the healthcare marketplace.

153. AWHC's activities arise in a business context and thus it is engaged in trade and commerce.

154. AWHC's actions are willful and knowing as it did so with the intent to manipulate the healthcare marketplace.

155. AWHC's willful violation of M.G.L. c. 93A, § 11 entitles the Plaintiff to injunctive relief, actual damages, treble damages, and reasonable attorney's fees and costs.

156. "[A]n act or practice is a violation of M.G.L. c.93A, § 2 if . . . [i]t fails to comply with existing statutes, rules, regulations or laws, meant for the protection of the public's health, safety, or welfare promulgated by the Commonwealth or any political subdivision thereof intended to provide the consumers of this Commonwealth protection." 940 Mass. Code Regs. 3.16(3).

157. The Department of Public Health's authorizing statute, including M.G.L. ch. 111 § 51, and regulations require that an entity advertised, announced, established, or maintained for the

purpose of providing ambulatory medical services, including performing ultrasounds, must be licensed with the Department of Public Health.

158. The Department of Public Health authorizing statute and its regulations are meant for the protection of the public health.

159. The Defendants advertise, announce, establish, and maintain AWHC as providing ambulatory medical services, including ultrasounds.

160. AWHC is not licensed with the Department of Public Health.

161. AWHC advertising, announcing, establishing, and maintaining AWHC as an ambulatory medical service without a license violates the Department of Public Health statute and regulations.

162. AWHC's activities arise in a business context and thus it is engaged in trade and commerce.

163. AWHC's actions are willful and knowing as it did so with the intent to manipulate the healthcare marketplace.

164. AWHC violation of these statutes and regulations is a violation of M.G.L. c. 93A and 940 Mass. Code Regs. 3.16(3).

165. AWHC's willful violation of M.G.L. c. 93A, § 11 entitles the Plaintiff to injunctive relief, actual damages, treble damages, and reasonable attorney's fees and costs.

PRAYER FOR RELIEF

WHEREFORE, Four Women respectfully pray that this Court:

a. Enter judgment in favor of Four Women and against AWHC on all counts of the Complaint;

b. Enter preliminary and permanent injunctions preventing AWHC from:

i. Accessing any Four Women computer system;

ii. Obtaining or interfering with Four Women's communications with patients or prospective patients;

iii. Misleading and directing women seeking medical services at Four Women to enter AWHC's premises for consultations or ultrasounds;

iv. Providing ultrasounds or any diagnosis from ultrasounds;

v. Promoting itself in any way as providing a team of board-certified doctors and nurses that utilize ultrasounds to diagnose the viability of a pregnancy;

vi. Promoting itself in any way as providing the full range of appropriate and standard medical care and instead disclose that its purpose is to deter and prevent abortion; and

vii. Communicating with or contacting Four Women patients or prospective patients.

c. Award damages as follows:

i. Award statutory damages of $100 a day for each day of violation or $10,000, whichever is greater, pursuant to 18 U.S.C § 2520(a)-(c).

ii. Award statutory damages of $100 per day for each day of violation or $1,000, whichever is greater, pursuant to M.G.L. c. 272, § 99.

iii. Award treble damages and interest pursuant to M.G.L. c. 93A, § 11 for unfair trade practices.

d. Award Four Women the cost of this action; and

e. Award such other and further relief as the Court may deem just and proper.

DEMAND FOR JURY TRIAL

Plaintiff Four Women demands a trial by jury on all issues so triable.

DATED: September 5, 2024

Four Women Health Services, LLC,

By its attorneys,

/s/ *Matthew Patton*
Matthew D. Patton (BBO No. 703798)
Law Office of Nicholas F. Ortiz, P.C.
One Boston Place, Suite 2600
Boston, MA 02108
(617) 338-9400
mdp@mass-legal.com

/s/ *Emily Nash*
Martha Coakley (BBO #87300)
Emily J. Nash (BBO #696460)
Caroline Holliday (BBO #707301)
FOLEY HOAG LLP
155 Seaport Boulevard
Boston, MA 02210
Telephone: (617) 832-1000
Facsimile: (617) 832-7000
mcoakley@foleyhoag.com
enash@foleyhoag.com

Brenna Rosen (*pro hac vice forthcoming*)
FOLEY HOAG LLP
1301 Avenue of the Americas
New York, New York 10019
brosen@foleyhoag.com

EXHIBIT A

LAW OFFICE OF THOMAS M. HARVEY

ATTORNEY AND COUNSELOR AT LAW
22 MILL STREET • SUITE 408
ARLINGTON, MASSACHUSETTS 02476

(617) 710-3616
FAX (781) 643-1126
email: tharveyesq@aol.com

June 22, 2022

Marcus Gordon, M.D.
Four Women Health Services, LLC
150 Emory Street, #2
Attleboro, MA 02703

Re: Attleboro Women's Health Center

Dear Dr. Gordon:

I represent the Attleboro Women's Health Center. It has come to my attention that it appears that members of your staff at Four Women Health Services, LLC, have engaged in illegal and libelous activities regarding the Attleboro Women's Health Center. Specifically, these actions include mail tampering, trespass, harassing phone calls, and libelous Google reviews and Facebook posts.

You are hereby forewarned. If there is one more incidence of this type of activity, then the Attleboro Women's Health Center will file the appropriate criminal and / or civil action against you and Four Women Health Services. Further, pursuant to G.L. Ch. 93A, Sec. 11, the Attleboro Women's Health Center will be seeking recovery of multiple damages and its reasonable attorneys' fees in compensation for your unfair business practices.

Very truly yours,

Thomas M. Harvey

FOLEY HOAG LLP

Seaport West
155 Seaport Boulevard
Boston, MA 02210-2600

617.832.1000 main
617.832.7000 fax

Martha M. Coakley
617-832-1129 direct
mcoakley@foleyhoag.com

August 16, 2022

Via E-mail

Thomas M. Harvey
22 Mill Street, Suite 408
Arlington, MA 02476
tharveyesq@aol.com

Re: Your June 22, 2022 Letter on Behalf of Attleboro Women's Health Center

Dear Mr. Harvey,

I am writing on behalf of Four Women Health Services, LLC ("Four Women") in response to your letter sent on June 22, 2022 on behalf of Attleboro Women's Health Center ("AWHC"). In your letter, you accused Four Women of engaging in a variety of actions you characterized as "illegal and libelous." This accusation is wholly unfounded: Four Women has not engaged in any of the activities enumerated in your letter nor any conduct that could amount to a violation of applicable law.

Your letter fails to identify any specific information associated with the conduct alleged therein. Your broad claim that Four Women has engaged in activity potentially warranting legal sanction appears calculated to harass, rather than address any legitimate concerns held by AWHC. If you have evidence of specific incidents related to any of the activity described in your letter, I encourage you to provide this information to me at Foley Hoag LLP. In the meantime, however, Four Women has assessed and investigated your generalized assertions and denies them in full.

Four Women has provided essential reproductive health care to its patients for almost 25 years and always seeks to ensure that its patients are able to obtain Four Women's services in a safe environment. Four Women understands well the harm that harassment, threats, and misinformation can cause to patients seeking sensitive and critical health services. To this end, Four Women prioritizes not only complying with all applicable law, but also maintaining a peaceful presence in the community to protect its patients. Four Women hopes that its neighbors follow similar principles.

Should you wish to discuss this matter further, please direct all future correspondence to me.

Cordially,

Martha Coakley

Of Counsel

CC: Caroline Donovan, Esq.
Emily Nash, Esq.

EXHIBIT B

Has your pregnancy been confirmed by ultrasound?

Ectopic pregnancy is when a pregnancy grows outside the uterus. Ectopic pregnancy is very serious and needs to be treated. A ruptured ectopic pregnancy can cause internal bleeding, infection, and in some cases lead to death.

Are you experiencing abdominal pain, vaginal bleeding, shoulder pain, feeling weak, dizzy or fainting? You may have a serious ectopic pregnancy and abortion is dangerous.

Abortion Pill (RU-486) - Performed up to 10 weeks of pregnancy

The Abortion Pill consists of two medications which work together to terminate a pregnancy. At the office you will take the first pill, Mifepristone. The pill works to block the production of Progesterone. This will cause the lining of the uterus to break down, cutting off the lifeline to the developing fetus.

24-48 hours later you will take the second pill, Misoprostol. This will cause contractions which will expel the contents of your uterus, including the lining of the uterine walls along with the deceased fetus and sac.

After taking the second pill you may experience heavy bleeding, cramping, possible diarrhea, and lactation from your nipples. Other symptoms may include: dizziness, nausea, abdominal pain, and mild fever or chills.

You will be encouraged to watch for the passing of large blood clots and bodily tissue. It will take from a few hours to several days to fully pass the fetus; however, bleeding may last up to a few weeks. (*If you experience excessive bleeding, blood clots that occur for more than 2 hours, fever, nausea or diarrhea for more than 24 hours, foul smelling discharge, pregnancy symptoms, or extreme depression please contact your doctor immediately.)*

If you're not a candidate for the abortion pill (non-surgical) or if the abortion pill fails, a surgical abortion would be necessary. Some of the most common surgical abortion procedures include:

Vacuum Aspiration (D&C) Performed up to 13 weeks of pregnancy

Requires a local anesthetic injected into or near the cervix. The cervix is then stretched open, allowing a tube to be inserted. The unborn baby and placenta are then suctioned out. Occasionally, this is followed by a procedure to scrape the walls of the uterus, making sure it has been completely emptied.

Dilation and Evacuation (D&E) Performed in weeks 13 to 24 of pregnancy (May required 2 to 3 visits)

Laminaria (seaweed) sticks and/or medication are placed into the cervix, slowly opening the cervix over a period of several hours or up to two days. You may be given intravenous medications to help with pain and to prevent infection. A general anesthesia may be given, and the unborn baby and placenta are then removed with forceps and suction curettage. It may be necessary to dismember the unborn baby.

100% SURE of your choice? If not, WAIT! You have time to explore your options.

Immediate Abortion Risks

Heavy bleeding (hemorrhage) or pelvic infection (sepsis)
Incomplete abortion
Cut or torn cervix or perforation of the wall of the uterus
Anesthesia-related complications
Rh Immune Globulin Disorders

Long Term Abortion Risks

Rh blood testing is required for all pregnancies to prevent the mother's body from rejecting future pregnancies. Future childbearing–in some cases, complications associated with abortion may make it difficult or impossible to carry a pregnancy to term in the future.

Psychological Abortion Risks

It is important to note that although many women experience a sense of relief initially following an abortion, some women encounter a variety of psychological effects. These range from irritability, difficulty sleeping, depression and even post-traumatic stress disorder. It is helpful for a woman to speak with someone if she is experiencing these symptoms.

Abortion Pill Reversal.com

Regret taking the abortion pill?

It may not be too late

Call Now 877-558-0333

No Insurance Required

A Story of Regret

"I went back into the waiting room and when they called me back I was taken to a room with an ultra-sound machine. I remember lying down and the doctor checking to see how far along I was. I remember seeing my baby. The doctor then gave me the first abortion pill (mifepristone RU-486). I took the pill with no hesitation. I just wanted out of there and didn't want to think about it ever again. I had to take the second pill the next day so the abortion process would finish. I remember hours after taking the second pill excruciating pain, cry-ing and bleeding. My husband was with me that whole night and neither of us got any sleep. After the abortion we never spoke about it again, but it never left my mind. The guilt haunts me until this day. I think about how old my baby would be and if it would have been a boy or girl."

EXHIBIT C

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

INTERIM UPDATE

ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 193, MARCH 2018

(Replaces Practice Bulletin Number 191, February 2018)

Committee on Practice Bulletins—Gynecology. This Practice Bulletin was developed by the Committee on Practice Bulletins—Gynecology in collaboration with Kurt T. Barnhart, MD, MSCE; and Jason M. Franasiak, MD, TS (ABB).

INTERIM UPDATE: This Practice Bulletin is updated as highlighted to clarify the guidance on the assessment of hCG levels after uterine aspiration in women with a pregnancy of unknown location.

Tubal Ectopic Pregnancy

Ectopic pregnancy *is defined as a pregnancy that occurs outside of the uterine cavity. The most common site of ectopic pregnancy is the fallopian tube. Most cases of tubal ectopic pregnancy that are detected early can be treated successfully either with minimally invasive surgery or with medical management using methotrexate. However, tubal ectopic pregnancy in an unstable patient is a medical emergency that requires prompt surgical intervention. The purpose of this document is to review information on the current understanding of tubal ectopic pregnancy and to provide guidelines for timely diagnosis and management that are consistent with the best available scientific evidence.*

Background

Epidemiology

According to the Centers for Disease Control and Prevention, ectopic pregnancy accounts for approximately 2% of all reported pregnancies (1). However, the true current incidence of ectopic pregnancy is difficult to estimate because many patients are treated in an outpatient setting where events are not tracked, and national surveillance data on ectopic pregnancy have not been updated since 1992 (1). Despite improvements in diagnosis and management, ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity. In 2011–2013, ruptured ectopic pregnancy accounted for 2.7% of all pregnancy-related deaths and was the leading cause of hemorrhage-related mortality (2). The prevalence of ectopic pregnancy among women presenting to an emergency department with first-trimester vaginal bleeding, or abdominal pain, or both, has been reported to be as high as 18% (3).

Etiology

The fallopian tube is the most common location of ectopic implantation, accounting for more than 90% of cases (4). However, implantation in the abdomen (1%), cervix (1%), ovary (1–3%), and cesarean scar (1–3%) can occur and often results in greater morbidity because of delayed diagnosis and treatment (4). An ectopic pregnancy also can co-occur with an intrauterine pregnancy, a condition known as heterotopic pregnancy. The risk of heterotopic pregnancy among women with a naturally achieved pregnancy is estimated to range from 1 in 4,000 to 1 in 30,000, whereas the risk among women who have undergone in vitro fertilization is estimated to be as high as 1 in 100 (5, 6).

Risk Factors

One half of all women who receive a diagnosis of an ectopic pregnancy do not have any known risk factors (3). Women with a history of ectopic pregnancy are at increased risk of recurrence. The chance of a repeat ectopic pregnancy in a woman with a history of one ectopic pregnancy is approximately 10% (odds ratio [OR] 3.0; 95% CI, 2.1–4.4). In a woman with two or more prior ectopic pregnancies, the risk of recurrence increases to more than 25% (OR, 11.17; 95% CI, 4.0–29.5) (3). Other important risk factors for ectopic pregnancy include previous damage to the fallopian tubes, factors secondary to ascending pelvic infection, and prior pelvic or fallopian tube surgery (3, 7). Among women who become pregnant through the use of assisted reproductive technology, certain factors such as tubal factor infertility and multiple

embryo transfer are associated with an increased risk of ectopic pregnancy (8, 9). Women with a history of infertility also are at increased risk of ectopic pregnancy independent of how they become pregnant (7). Other less significant risk factors include a history of cigarette smoking and age older than 35 years (7).

Women who use an intrauterine device (IUD) have a lower risk of ectopic pregnancy than women who are not using any form of contraception because IUDs are highly effective at preventing pregnancy. However, up to 53% of pregnancies that occur with an IUD in place are ectopic (10). Factors such as oral contraceptive use, emergency contraception failure, previous elective pregnancy termination, pregnancy loss, and cesarean delivery have not been associated with an increased risk of ectopic pregnancy (3, 7, 11, 12).

Clinical Considerations and Recommendations

▶ ***How is an ectopic pregnancy diagnosed?***

The minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy. Serial evaluation with transvaginal ultrasonography, or serum hCG level measurement, or both, often is required to confirm the diagnosis.

Women with clinical signs and physical symptoms of a ruptured ectopic pregnancy, such as hemodynamic instability or an acute abdomen, should be evaluated and treated urgently. Early diagnosis is aided by a high index of suspicion. Every sexually active, reproductive-aged woman who presents with abdominal pain or vaginal bleeding should be screened for pregnancy, regardless of whether she is currently using contraception (13, 14). Women who become pregnant and have known significant risk factors should be evaluated for possible ectopic pregnancy even in the absence of symptoms.

Transvaginal Ultrasonography

Ultrasonography can definitively diagnose an ectopic pregnancy when a gestational sac with a yolk sac, or embryo, or both, is noted in the adnexa (15, 16); however, most ectopic pregnancies do not progress to this stage (15). The ultrasound findings of a mass or a mass with a hypoechoic area that is separate from the ovary should raise suspicion for the presence of an ectopic pregnancy; however, its positive predictive value is only 80% (15) because these findings can be confused with pelvic structures, such as a paratubal cyst, corpus luteum, hydrosalpinx, endometrioma, or bowel. Although an early intrauterine gestational sac may be visualized as early as 5 weeks of gestation (17), definitive ultrasound evidence of an intrauterine pregnancy includes visualization of a gestational sac with a yolk sac or embryo (16). Visualization of a definitive intrauterine pregnancy eliminates ectopic pregnancy except in the rare case of a heterotopic pregnancy. Although a hypoechoic "sac-like" structure (including a "double sac sign") (18) in the uterus likely represents an intrauterine gestation, it also may represent a pseudogestational sac, which is a collection of fluid or blood in the uterine cavity that is sometimes visualized with ultrasonography in women with an ectopic pregnancy (19, 20).

Serum Human Chorionic Gonadotropin Measurement

Measurement of the serum hCG level aids in the diagnosis of women at risk of ectopic pregnancy. However, serum hCG values alone should not be used to diagnose an ectopic pregnancy and should be correlated with the patient's history, symptoms, and ultrasound findings (21, 22). Accurate gestational age calculation, rather than an absolute hCG level, is the best determinant of when a normal pregnancy should be seen within the uterus with transvaginal ultrasonography (23, 24). An intrauterine gestational sac with a yolk sac should be visible between 5 weeks and 6 weeks of gestation regardless of whether there are one or multiple gestations (25, 26). In the absence of such definitive information, the serum hCG level can be used as a surrogate for gestational age to help interpret a nondiagnostic ultrasonogram.

The "discriminatory level" is the concept that there is a hCG value above which the landmarks of a normal intrauterine gestation should be visible on ultrasonography. The absence of a possible gestational sac on ultrasound examination in the presence of a hCG measurement above the discriminatory level strongly suggests a nonviable gestation (an early pregnancy loss or an ectopic pregnancy). In 50–70% of cases, these findings are consistent with an ectopic pregnancy (27–29). However, the utility of the hCG discriminatory level has been challenged (24) in light of a case series that noted ultrasonography confirmation of an intrauterine gestational sac on follow-up when no sac was noted on initial scan and the serum hCG level was above the discriminatory level (30–32). If the concept of the hCG discriminatory level is to be used as a diagnostic aid in women at risk of ectopic pregnancy, the value should be conservatively high (eg, as high as 3,500 mIU/mL) to avoid the potential for misdiagnosis and possible interruption of an intrauterine pregnancy that a woman hopes to continue (24, 32). Women with a multiple gestation have higher hCG levels than those with a single gestation at any given gestational age and may have hCG levels above traditional discriminatory hCG levels before ultrasonography recognition (24).

Trends of Serial Serum Human Chorionic Gonadotropin

A single hCG concentration measurement cannot diagnose viability or location of a gestation. Serial hCG concentration measurements are used to differentiate normal from abnormal pregnancies (21, 22, 33, 34). When clinical findings suggest an abnormal gestation, a second hCG value measurement is recommended 2 days after the initial measurement to assess for an increase or decrease. Subsequent assessments of hCG concentration should be obtained 2–7 days apart, depending on the pattern and the level of change.

In early pregnancy, serum hCG levels increase in a curvilinear fashion until a plateau at 100,000 mIU/mL by 10 weeks of gestation. Guidelines regarding the minimal increase in hCG for a potentially viable intrauterine pregnancy have become more conservative (ie, slower increase) (21, 22) and have been demonstrated to be dependent on the initial value (35). There is a slower than expected increase in serum hCG levels for a normal gestation when initial values are high. For example, the expected rate of increase is 49% for an initial hCG level of less than 1,500 mIU/mL, 40% for an initial hCG level of 1,500–3,000 mIU/mL, and 33% for an initial hCG level greater than 3,000 mIU/mL (35). In early pregnancy, an increase in serum hCG of less than a minimal threshold in 48 hours is suspicious of an abnormal pregnancy (ectopic or early pregnancy loss) because 99% of normal intrauterine pregnancies will have a rate of increase faster than this minimum. However, even hCG patterns consistent with a growing or resolving gestation do not eliminate the possibility of an ectopic pregnancy (36).

Decreasing hCG values suggest a failing pregnancy and may be used to monitor spontaneous resolution, but this decrease should not be considered diagnostic. Approximately 95% of women with a spontaneous early pregnancy loss will have a decrease in hCG concentration of 21–35% in 2 days depending on initial hCG levels (34). A woman with decreasing hCG values and a possible ectopic pregnancy should be monitored until nonpregnant levels are reached because rupture of an ectopic pregnancy can occur while levels are decreasing or are very low.

Pregnancy of Unknown Location

A pregnant woman without a definitive finding of an intrauterine or ectopic pregnancy on ultrasound examination has a "pregnancy of unknown location" (37). A pregnancy of unknown location should not be considered a diagnosis, rather it should be treated as a transient state and efforts should be made to establish a definitive diagnosis when possible (16). A woman with a pregnancy of unknown location who is clinically stable and has a desire to continue the pregnancy, if intrauterine, should have a repeat transvaginal ultrasound examination, or serial measurement of hCG concentration, or both, to confirm the diagnosis and guide management (22, 37). Follow-up to confirm a diagnosis of ectopic pregnancy in a stable patient, especially at first clinical encounter, is recommended to eliminate misdiagnosis and to avoid unnecessary exposure to methotrexate, which can lead to interruption or teratogenicity of an ongoing intrauterine pregnancy (16, 38, 39). The first step is to assess for the possibility that the gestation is advancing.

When the possibility of a progressing intrauterine gestation has been reasonably excluded, uterine aspiration can help to distinguish early intrauterine pregnancy loss from ectopic pregnancy by identifying the presence or absence of intrauterine chorionic villi. Choosing the appropriate time and intervention should be done through shared decision making, incorporating the patient's values and preferences regarding maternal risk and the possibility of interrupting a progressing pregnancy. If chorionic villi are found, then failed intrauterine pregnancy is confirmed and no further evaluation is necessary. If chorionic villi are not confirmed, hCG levels should be monitored, with the first measurement taken 12–24 hours after aspiration. A plateau or increase in hCG postprocedure suggests that evacuation was incomplete or there is a nonvisualized ectopic pregnancy, and further treatment is warranted. Although the change at which hCG is considered to have plateaued is not precisely defined, it would be reasonable to consider levels to have plateaued if they have decreased by less than 10–15%. Large decreases in hCG levels are more consistent with failed intrauterine pregnancy than ectopic pregnancy. In two small series of women undergoing uterine aspiration for pregnancy of unknown location, nearly all women with a decrease in hCG levels of 50% or greater within 12–24 hours after aspiration had failed intrauterine pregnancies (29, 40). Patients with a decrease in hCG of 50% or greater can be monitored with serial hCG measurements, with further treatment reserved for those whose levels plateau or increase, or who develop symptoms of ectopic pregnancy. Management of patients with an hCG decrease of less than 50% should be individualized, as while failed intrauterine pregnancy is more frequent, ectopic pregnancy risk is appreciable. One study (29) noted 55.6% of patients with ectopic pregnancies had an hCG decrease of more than 10%, 23.5% had a decrease of more than 30%, and 7.1% had a decrease of more than 50%. In a series of patients who had an initial decrease of hCG levels between 15% and 50% 12–24 hours after office uterine aspiration for pregnancy

of unknown location who were monitored with serial hCG measurement, 3 of 46 patients had rising or plateauing hCG levels necessitating treatment for ectopic pregnancy (41). The other patients had resolving hCG levels, and were presumed to have failed intrauterine pregnancies. Patients with an hCG decline between 15% and 50% 12–24 hours after aspiration require at least close follow-up with serial hCG measurement, with consideration of treatment for ectopic pregnancy based on clinical factors such as plateau or increase in hCG, development of symptoms, or high clinical suspicion or strong risk factors for ectopic pregnancy (29, 40, 41).

There is debate among experts about the need to determine pregnancy location by uterine aspiration before providing methotrexate (42, 43). Proponents cite the importance of confirming the diagnosis to avoid unnecessary exposure to methotrexate and to help guide management of the current pregnancy and future pregnancies (37, 42). Arguments against the need for a definitive diagnosis include concern about the increased risk of tubal rupture because of delay in treatment while diagnosis is established and the increased health-care costs associated with additional tests and procedures (43). However, with close follow-up during this diagnostic phase, the risk of rupture is low. In one large series with serial hCG measurement of women with pregnancies of unknown location, the risk of rupture of an ectopic pregnancy during surveillance to confirm diagnosis was as low as 0.03 % among all women at risk and as low as 1.7% among all ectopic pregnancies diagnosed (22). In addition, presumptive treatment with methotrexate has not been found to confer a significant cost savings or to decrease the risk of complications (44). The choice of performing a uterine aspiration before treatment with methotrexate should be guided by a discussion with the patient regarding the benefits and risks, including the risk of teratogenicity in the case of an ongoing intrauterine pregnancy and exposure to methotrexate.

▶ *Who are candidates for medical management of ectopic pregnancy?*

Medical management with methotrexate can be considered for women with a confirmed or high clinical suspicion of ectopic pregnancy who are hemodynamically stable, who have an unruptured mass, and who do not have absolute contraindications to methotrexate administration (45). These patients generally also are candidates for surgical management. The decision for surgical management or medical management of ectopic pregnancy should be guided by the initial clinical, laboratory, and radiologic data as well as patient-informed choice based on a discussion of the benefits and risks of each approach. Women who choose methotrexate therapy should be counseled about the importance of follow-up surveillance.

Methotrexate

Methotrexate is a folate antagonist that binds to the catalytic site of dihydrofolate reductase, which interrupts the synthesis of purine nucleotides and the amino acids serine and methionine, thereby inhibiting DNA synthesis and repair and cell replication. Methotrexate affects actively proliferating tissues, such as bone marrow, buccal and intestinal mucosa, respiratory epithelium, malignant cells, and trophoblastic tissue. Systemic methotrexate has been used to treat gestational trophoblastic disease since 1956 and was first used to treat ectopic pregnancy in 1982 (46). There are no recommended alternative medical treatment strategies for ectopic pregnancy beyond intramuscular methotrexate. Although oral methotrexate therapy for ectopic pregnancy has been studied, the outcomes data are sparse and indicate that benefits are limited (47).

Contraindications

Box 1 lists absolute and relative contraindications to methotrexate therapy (45). Before administering methotrexate, it is important to reasonably exclude the presence of an intrauterine pregnancy. In addition, methotrexate administration should be avoided in patients with clinically significant elevations in serum creatinine, liver transaminases, or bone marrow dysfunction indicated by significant anemia, leukopenia, or thrombocytopenia. Because methotrexate affects all rapidly dividing tissues within the body, including bone marrow, the gastrointestinal mucosa, and the respiratory epithelium, it should not be given to women with blood dyscrasias or active gastrointestinal or respiratory disease. However, asthma is not an exclusion to the use of methotrexate. Methotrexate is directly toxic to the hepatocytes and is cleared from the body by renal excretion; therefore, methotrexate typically is not used in women with liver or kidney disease.

Relative contraindications for the use of methotrexate (Box 1) do not serve as absolute cut-offs but rather as indicators of potentially reduced effectiveness in certain settings. For example, a high initial hCG level is considered a relative contraindication. Systematic review evidence shows a failure rate of 14.3% or higher with methotrexate when pretreatment hCG levels are higher than 5,000 mIU/mL compared with a 3.7% failure rate for hCG levels less than 5,000 mIU/mL (48). Of note, studies often have excluded patients from methotrexate treatment when hCG levels are greater than

Box 1. Contraindications to Methotrexate Therapy

Absolute Contraindications

- Intrauterine pregnancy
- Evidence of immunodeficiency
- Moderate to severe anemia, leukopenia, or thrombocytopenia
- Sensitivity to methotrexate
- Active pulmonary disease
- Active peptic ulcer disease
- Clinically important hepatic dysfunction
- Clinically important renal dysfunction
- Breastfeeding
- Ruptured ectopic pregnancy
- Hemodynamically unstable patient
- Inability to participate in follow-up

Relative Contraindications

- Embryonic cardiac activity detected by transvaginal ultrasonography
- High initial hCG concentration
- Ectopic pregnancy greater than 4 cm in size as imaged by transvaginal ultrasonography
- Refusal to accept blood transfusion

Modified from Medical treatment of ectopic pregnancy: a committee opinion. Practice Committee of American Society for Reproductive Medicine. Fertil Steril 2013;100:638–44.

5,000 mIU/mL based on expert opinion that these levels are a relative contraindication to medical management. Other predictors of methotrexate treatment failure include the presence of an advanced or rapidly growing gestation (as evidenced by fetal cardiac activity) and a rapidly increasing hCG concentration (greater than 50% in 48 hours) (48–50).

▶ *What methotrexate regimens are used in the management of ectopic pregnancy, and how do they compare in effectiveness and risk of adverse effects?*

There are three published protocols for the administration of methotrexate to treat ectopic pregnancy: 1) a single-dose protocol (51), 2) a two-dose protocol (52), and 3) a fixed multiple-dose protocol (53) (Box 2). The single-dose regimen is the simplest of the three regimens; however, an additional dose may be required to ensure resolution in up to one quarter of patients (54, 55). The two-dose regimen was first proposed in 2007 in an effort to combine the efficacy of the multiple-dose protocol with the favorable adverse effect profile of the single-dose regimen (55). The two-dose regimen adheres to the same hCG monitoring schedule as the single-dose regimen, but a second dose of methotrexate is administered on day 4 of treatment. The multiple-dose methotrexate regimen involves up to 8 days of treatment with alternating administration of methotrexate and folinic acid, which is given as a rescue dose to minimize the adverse effects of the methotrexate.

The overall treatment success of systemic methotrexate for ectopic pregnancy, defined as resolution of the ectopic pregnancy without the need for surgery, in observational studies ranges from approximately 70% to 95% (55). Resolution of an ectopic pregnancy may depend on the methotrexate treatment regimen used and the initial hCG level. However, there is no clear consensus in the literature regarding the optimal methotrexate regimen for the management of ectopic pregnancy. The choice of methotrexate protocol should be guided by the initial hCG level and discussion with the patient regarding the benefits and risks of each approach. In general, the single-dose protocol may be most appropriate for patients with a relatively low initial hCG level or a plateau in hCG values, and the two-dose regimen may be considered as an alternative to the single-dose regimen, particularly in women with an initial high hCG value.

Single-Dose Versus Multiple-Dose

Observational studies that compared the single-dose and multiple-dose regimens have indicated that although the multiple-dose regimen is statistically more effective (92.7% versus 88.1%, respectively; *P*=.035) (single-dose

Box 2. Methotrexate Treatment Protocols

Single-dose regimen*

- Administer a single dose of methotrexate at a dose of 50 mg/m^2 intramuscularly on day 1
- Measure hCG level on posttreatment day 4 and day 7
  - If the decrease is greater than 15%, measure hCG levels weekly until reaching nonpregnant level
  - If decrease is less than 15%, readminister methotrexate at a dose of 50 mg/m^2 intramuscularly and repeat hCG level
  - If hCG does not decrease after two doses, consider surgical management
- If hCG levels plateau or increase during follow-up, consider administering methotrexate for treatment of a persistent ectopic pregnancy

***Two-dose regimen*†**

- Administer methotrexate at a dose of 50 mg/m^2 intramuscularly on day 1
- Administer second dose of methotrexate at a dose of 50 mg/m^2 intramuscularly on day 4
- Measure hCG level on posttreatment day 4 and day 7
  - If the decrease is greater than 15%, measure hCG levels weekly until reaching nonpregnant level
  - If decrease is less than 15%, readminister methotrexate 50 mg/m^2 intramuscularly on day 7 and check hCG levels on day 11
  - If hCG levels decrease 15% between day 7 and day 11, continue to monitor weekly until reaching nonpregnant levels
  - If the decrease is less than 15% between day 7 and day 11, readminister dose of methotrexate 50 mg/m^2 intramuscularly on day 11 and check hCG levels on day 14
  - If hCG does not decrease after four doses, consider surgical management
- If hCG levels plateau or increase during follow-up, consider administering methotrexate for treatment of a persistent ectopic pregnancy

***Fixed multiple-dose regimen*‡**

- Administer methotrexate 1 mg/kg intramuscularly on days 1, 3, 5, 7; alternate with folinic acid 0.1 mg/kg intramuscularly on days 2, 4, 6, 8
- Measure hCG levels on methotrexate dose days and continue until hCG has decreased by 15% from its previous measurement
  - If the decrease is greater than 15%, discontinue administration of methotrexate and measure hCG levels weekly until reaching nonpregnant levels (may ultimately need one, two, three, or four doses)
  - If hCG does not decrease after four doses, consider surgical management
- If hCG levels plateau or increase during follow-up, consider administering methotrexate for treatment of a persistent ectopic pregnancy

Abbreviation: hCG, human chorionic gonadotropin.

*Stovall TG, Ling FW. Single-dose methotrexate: an expanded clinical trial. Am J Obstet Gynecol 1993;168:1759-62; discussion 1762–5.

†Barnhart K, Hummel AC, Sammel MD, Menon S, Jain J, Chakhtoura N. Use of "2-dose" regimen of methotrexate to treat ectopic pregnancy. Fertil Steril 2007;87:250–6.

‡Rodi IA, Sauer MV, Gorrill MJ, Bustillo M, Gunning JE, Marshall JR, et al. The medical treatment of unruptured ectopic pregnancy with methotrexate and citrovorum rescue: preliminary experience. Fertil Steril 1986;46:811–3.

failure OR, 1.71; 95% CI, 1.04–2.82), the single-dose regimen is associated with a decreased risk of adverse effects (OR, 0.44; 95% CI, 0.31–0.63) (55). However, a more recent systematic review of randomized controlled trials showed similar rates of successful resolution with the single-dose and multiple-dose regimens (relative risk [RR], 1.07; 95% CI, 0.99–1.17) and an increased risk of adverse effects with the multiple-dose protocol (RR, 1.64; 95% CI, 1.15–2.34) (56).

Single-Dose Versus Two-Dose

A systematic review and meta-analysis of three randomized controlled trials showed similar rates of successful resolution for the two-dose and single-dose protocols (RR, 1.09; 95% CI 0.98–1.20) and comparable risk of adverse effects (RR, 1.33; 95% CI, 0.92–1.94) (56). However, in two of the three trials included in the review, the two-dose regimen was associated with greater success among women with high initial hCG levels. In the first trial, there was a nonstatistically significant trend toward greater success for the two-dose regimen in the subgroup with an initial hCG level greater than 5,000 mIU/mL (80.0% versus 58.8%, P=.279) (RR, 0.74; 95% CI, 0.47–1.16) (57). The second trial reported a statistically significant higher success rate for the two-dose regimen versus the single-dose regimen in patients with initial serum hCG levels between 3,600 mIU/mL and 5,500 mIU/mL (88.9% versus 57.9%, P=.03) (OR 5.80; 95% CI, 1.29–26.2) (58).

▶ What surveillance is needed after methotrexate treatment?

After administration of methotrexate treatment, hCG levels should be serially monitored until a nonpregnancy level (based upon the reference laboratory assay) is reached (51). Close monitoring is required to ensure disappearance of trophoblastic activity and to eliminate the possibility of persistent ectopic pregnancy. During the first few days after treatment, the hCG level may increase to levels higher than the pretreatment level but then should progressively decrease to reach a nonpregnant level (51). Failure of the hCG level to decrease by at least 15% from day 4 to day 7 after methotrexate administration is associated with a high risk of treatment failure and requires additional methotrexate administration (in the case of the single-dose or two-dose regimen) or surgical intervention (51). Methotrexate treatment failure in patients who did not undergo pretreatment uterine aspiration should raise concern for the presence of an abnormal intrauterine gestation. In these patients, uterine aspiration should be considered before repeat methotrexate administration or surgical management, unless there is clear evidence of a tubal ectopic pregnancy. Ultrasound surveillance of resolution of an ectopic pregnancy is not routinely indicated because findings do not predict rupture or time to resolution (59, 60). Resolution of serum hCG levels after medical management is usually complete in 2–4 weeks but can take up to 8 weeks (55). The resolution of hCG levels is significantly faster in patients successfully treated with the two-dose methotrexate regimen compared with the single-dose regimen (25.7+13.6 versus 31.9+14.1 days; P>.025) (57).

▶ What are the potential adverse effects of systemic methotrexate administration?

Adverse effects of methotrexate usually are dependent on dose and treatment duration. Because methotrexate affects rapidly dividing tissues, gastrointestinal problems (eg, nausea, vomiting, and stomatitis) are the most common adverse effects after multiple doses. Vaginal spotting is expected. It is not unusual for women treated with methotrexate to experience abdominal pain 2–3 days after administration, presumably from the cytotoxic effect of the drug on the trophoblastic tissue. In the absence of signs and symptoms of overt tubal rupture and significant hemoperitoneum, abdominal pain usually can be managed expectantly by monitoring a woman's hemoglobin level and intraperitoneal fluid amount with transvaginal ultrasonography.

Elevation of liver enzymes is a less commonly reported adverse effect and typically resolves after discontinuing methotrexate use (61). Alopecia also is a rare adverse effect of the low doses used to treat ectopic pregnancy. Cases of pneumonitis also have been reported, and women should be counseled to report any fever or respiratory symptoms to their physicians (62).

▶ How should women be counseled regarding the treatment effects of methotrexate?

Patients treated with methotrexate should be counseled about the risk of ectopic pregnancy rupture; about avoiding certain foods, supplements, or drugs that can decrease efficacy; and about the importance of not becoming pregnant again until resolution has been confirmed. It is important to educate patients about the symptoms of tubal rupture and to emphasize the need to seek immediate medical attention if these symptoms occur. Vigorous activity and sexual intercourse should be avoided until confirmation of resolution because of the theoretical risk of inducing rupture of the ectopic pregnancy. Additionally, practitioners should limit pelvic and ultrasound examinations when possible. Patients should be advised to avoid folic acid supplements, foods

that contain folic acid, and nonsteroidal antiinflammatory drugs during therapy because these products may decrease the efficacy of methotrexate. Avoidance of narcotic analgesic medications, alcohol, and gas-producing foods are recommended so as not to mask, or be confused with, escalation of symptoms of rupture. Sunlight exposure also should be avoided during treatment to limit the risk of methotrexate dermatitis (63).

Before treatment with methotrexate, women should be counseled about the potential for fetal death or teratogenic effects when administered during pregnancy. The product labeling approved by the U.S. Food and Drug Administration recommends that women avoid pregnancy during treatment and for at least one ovulatory cycle after methotrexate therapy (63). Methotrexate is cleared from the serum before the 4–12 weeks necessary for the resolution of the ectopic gestation and ovulation in the next cycle (64, 65). However, there are reports of methotrexate detectable in liver cells 116 days past exposure (66). Limited evidence suggests that the frequency of congenital anomalies or early pregnancy loss is not elevated in women who have become pregnant shortly after methotrexate exposure (66). However, perhaps based on the timing of methotrexate's clearance from the body, some experts continue to recommend that women delay pregnancy for at least 3 months after the last dose of methotrexate (67).

▶ *How does methotrexate treatment affect subsequent fertility?*

Patients can be counseled that available evidence, although limited, suggests that methotrexate treatment of ectopic pregnancy does not have an adverse effect on subsequent fertility or on ovarian reserve. A prospective observational study noted no difference in anti-müllerian hormone levels or reproductive outcomes after administration of methotrexate (68). Furthermore, a systematic review of women undergoing fertility treatment found no significant differences in the mean number of oocytes retrieved during the cycles before and after methotrexate administration (69).

▶ *Who are candidates for surgical management of ectopic pregnancy?*

In clinically stable women in whom a nonruptured ectopic pregnancy has been diagnosed, laparoscopic surgery or intramuscular methotrexate administration are safe and effective treatments. The decision for surgical management or medical management of ectopic pregnancy should be guided by the initial clinical, laboratory, and radiologic data as well as patient-informed choice based on a discussion of the benefits and risks of each approach. Surgical management of ectopic pregnancy is required when a patient is exhibiting any of the following: hemodynamic instability, symptoms of an ongoing ruptured ectopic mass (such as pelvic pain), or signs of intraperitoneal bleeding.

Surgical management is necessary when a patient meets any of the absolute contraindications to medical management listed in Box 1 and should be considered when a patient meets any of the relative contraindications. Surgical management should be employed when a patient who initially elects medical management experiences a failure of medical management. Surgical treatment also can be considered for a clinically stable patient with a nonruptured ectopic pregnancy or when there is an indication for a concurrent surgical procedure, such as tubal sterilization or removal of hydrosalpinx when a patient is planning to undergo subsequent in vitro fertilization.

Surgical management generally is performed using laparoscopic salpingectomy (removal of part or all of the affected fallopian tube) or laparoscopic salpingostomy (removal of the ectopic pregnancy while leaving the affected fallopian tube in situ). Laparotomy typically is reserved for unstable patients, patients with a large amount of intraperitoneal bleeding, and patients in whom visualization has been compromised at laparoscopy.

▶ *How do medical management and surgical management of ectopic pregnancy compare in effectiveness and risk of complications?*

Medical management of ectopic pregnancy avoids the inherent risks of surgery and anesthesia. However, compared with laparoscopic salpingectomy, medical management of ectopic pregnancy has a lower success rate and requires longer surveillance, more office visits, and phlebotomy. Randomized trials that compared medical management of ectopic pregnancy with methotrexate to laparoscopic salpingostomy have demonstrated a statistically significant lower success rate with the use of single-dose methotrexate (relative rate for success, 0.82; 95% CI, 0.72–0.94) and no difference with the use of multidose methotrexate (relative rate for success, 1.8; 95% CI, 0.73–4.6) (70). Comparing systemic methotrexate with tube-sparing laparoscopic surgery, randomized trials have shown no difference in overall tubal preservation, tubal patency, repeat ectopic pregnancy, or future pregnancies (70).

Medical management of ectopic pregnancy is cost effective when laparoscopy is not needed to make the diagnosis and hCG values are less 1,500 mIU/mL (71). Surgical management of ectopic pregnancy is more cost

effective if time to resolution is expected to be prolonged, or there is a relatively high chance of medical management failure, such as in cases with high or increasing hCG values or when embryonic cardiac activity is detected (72, 73).

▶ *How do salpingostomy and salpingectomy compare in effectiveness and fertility outcomes in the management of ectopic pregnancy?*

The decision to perform a salpingostomy or salpingectomy for the treatment of ectopic pregnancy should be guided by the patient's clinical status, her desire for future fertility, and the extent of fallopian tube damage. Randomized controlled trials that compared salpingectomy with salpingostomy for the management of ectopic pregnancy have found no statistically significant difference in the rates of subsequent intrauterine pregnancy (RR, 1.04; 95% CI, 0.899–1.21) or repeat ectopic pregnancy (RR, 1.30; 95% CI, 0.72–2.38) (74). In contrast, cohort study findings indicate that salpingostomy is associated with a higher rate of subsequent intrauterine pregnancy (RR, 1.24; 95% CI, 1.08–1.42) but also with an increased risk of repeat ectopic pregnancy (10% versus 4%; RR, 2.27; 95% CI, 1.12–4.58) compared with salpingectomy (74).

In general, salpingectomy is the preferred approach when severe fallopian tube damage is noted and in cases in which there is significant bleeding from the proposed surgical site. Salpingectomy can be considered in cases of desired future fertility when the patient has a healthy contralateral fallopian tube. However, salpingostomy should be considered in patients who desire future fertility but have damage to the contralateral fallopian tube and in whom removal would require assisted reproduction for future childbearing. When salpingostomy is performed, it is important to monitor the patient with serial hCG measurement to ensure resolution of ectopic trophoblastic tissue. If there is concern for incomplete resection, a single prophylactic dose of methotrexate may be considered (45).

▶ *Who are candidates for expectant management of diagnosed ectopic pregnancy?*

There may be a role for expectant management of ectopic pregnancy in specific circumstances. Candidates for successful expectant management of ectopic pregnancy should be asymptomatic; should have objective evidence of resolution (generally, manifested by a plateau or decrease in hCG levels); and must be counseled and willing to accept the potential risks, which include tubal rupture, hemorrhage, and emergency surgery. If the initial hCG level is less than 200 mIU/mL, 88% of patients will experience spontaneous resolution; lower spontaneous resolution rates can be anticipated with higher hCG levels (75). In a single small randomized trial of women with hCG levels less than 2,000 mIU/mL, expectant management was not associated with a statistically significant lower treatment success than single-dose methotrexate for the management of ectopic pregnancy (59% versus 76%, respectively) (RR, 1.3; 95% CI, 0.9–1.8) (76). Reasons for abandoning expectant management include intractable or significantly increased pain, insufficient decrease of hCG levels, or tubal rupture with hemoperitoneum.

Summary of Recommendations

The following recommendations are based on good and consistent scientific evidence (Level A):

- In clinically stable women in whom a nonruptured ectopic pregnancy has been diagnosed, laparoscopic surgery or intramuscular methotrexate administration are safe and effective treatments. The decision for surgical management or medical management of ectopic pregnancy should be guided by the initial clinical, laboratory, and radiologic data as well as patient-informed choice based on a discussion of the benefits and risks of each approach.
- Surgical management of ectopic pregnancy is required when a patient is exhibiting any of the following: hemodynamic instability, symptoms of an ongoing ruptured ectopic mass (such as pelvic pain), or signs of intraperitoneal bleeding.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Serum hCG values alone should not be used to diagnose an ectopic pregnancy and should be correlated with the patient's history, symptoms, and ultrasound findings.
- If the concept of the hCG discriminatory level is to be used as a diagnostic aid in women at risk of ectopic pregnancy, the value should be conservatively high (eg, as high as 3,500 mIU/mL) to avoid the potential for misdiagnosis and possible interruption of an intrauterine pregnancy that a woman hopes to continue.
- The decision to perform a salpingostomy or salpingectomy for the treatment of ectopic pregnancy

should be guided by the patient's clinical status, her desire for future fertility, and the extent of fallopian tube damage.

- The choice of methotrexate protocol should be guided by the initial hCG level and discussion with the patient regarding the benefits and risks of each approach. In general, the single-dose protocol may be most appropriate for patients with a relatively low initial hCG level or a plateau in hCG values, and the two-dose regimen may be considered as an alternative to the single-dose regimen, particularly in women with an initial high hCG value.
- Failure of the hCG level to decrease by at least 15% from day 4 to day 7 after methotrexate administration is associated with a high risk of treatment failure and requires additional methotrexate administration (in the case of the single-dose or two-dose regimen) or surgical intervention.
- Patients can be counseled that available evidence, although limited, suggests that methotrexate treatment of ectopic pregnancy does not have an adverse effect on subsequent fertility or on ovarian reserve.
- There may be a role for expectant management of ectopic pregnancy in specific circumstances.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- The minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy. Serial evaluation with transvaginal ultrasonography, or serum hCG level measurement, or both, often is required to confirm the diagnosis.
- A woman with a pregnancy of unknown location who is clinically stable and has a desire to continue the pregnancy, if intrauterine, should have a repeat transvaginal ultrasound examination, or serial measurement of hCG concentration, or both, to confirm the diagnosis and guide management.
- Medical management with methotrexate can be considered for women with a confirmed or high clinical suspicion of ectopic pregnancy who are hemodynamically stable, who have an unruptured mass, and who do not have absolute contraindications to methotrexate administration.
- After administration of methotrexate treatment, hCG levels should be serially monitored until a nonpregnancy level (based upon the reference laboratory assay) is reached.
- Patients treated with methotrexate should be counseled about the risk of ectopic pregnancy rupture; about avoiding certain foods, supplements, or drugs that can decrease efficacy; and about the importance of not becoming pregnant again until resolution has been confirmed.

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71. Mol BW, Swart P, Bossuyt PM, van der Veen F. Prognostic significance of diagnostic laparoscopy for spontaneous fertility. J Reprod Med 1999;44:81–6. (Level II-2) ⇦

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73. Sowter MC, Farquhar CM, Gudex G. An economic evaluation of single dose systemic methotrexate and laparoscopic surgery for the treatment of unruptured ectopic pregnancy. BJOG 2001;108:204–12. (Cost-analysis) ⇦

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76. van Mello NM, Mol F, Verhoeve HR, van Wely M, Adriaanse AH, Boss EA, et al. Methotrexate or expectant management in women with an ectopic pregnancy or pregnancy of unknown location and low serum hCG concentrations? A randomized comparison. Hum Reprod 2013;28:60–7. (Level I) ⇦

American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920

Tubal ectopic pregnancy. ACOG Practice Bulletin No. 193. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018; 131:e91–103.

The MEDLINE database, the Cochrane Library, and ACOG's own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 2000 and September 2017. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles. When reliable research was not available, expert opinions from obstetrician–gynecologists were used.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I	Evidence obtained from at least one properly designed randomized controlled trial.
II-1	Evidence obtained from well-designed controlled trials without randomization.
II-2	Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.
II-3	Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
III	Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Four Women Health Services, LLC

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Matthew D. Patton (BBO No. 703798)
Law Office of Nicholas F. Ortiz, P.C.
One Boston Place, Suite 2600

DEFENDANTS

Abundant Hope Pregnancy Resource Center Inc., d/b/a Attleboro Women's Health Center, Catherine Roman,

County of Residence of First Listed Defendant Bristol
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☒ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
18 U.S.C. § 1030, et seq., 18 U.S.C. § 2510, et seq., 28 U.S.C. § 1367

Brief description of cause:
Action against defendant for violations of CFAA and Wiretap Acts to obtain confidential patient information and violation of state consumer protecti

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
September 5, 2024

SIGNATURE OF ATTORNEY OF RECORD
/s/ Matthew Patton

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

1. **Title of case (name of first party on each side only)** Four Women v. Abundant Hope Pregnancy Resource Center Inc., d/b/a Attleboro Women's Health Center

2. **Category in which the case belongs based upon the numbered nature of suit code listed on the civil cover sheet. (See local rule 40.1(a)(1)).**

☐ **I.** 160, 400, 410, 441, 535, 830*, 835*, 850, 880, 891, 893, R.23, REGARDLESS OF NATURE OF SUIT.

☐ **II.** 110, 130, 190, 196, 370, 375, 376, 440, 442, 443, 445, 446, 448, 470, 751, 820*, 840*, 895, 896, 899.

☑ **III.** 120, 140, 150, 151, 152, 153, 195, 210, 220, 230, 240, 245, 290, 310, 315, 320, 330, 340, 345, 350, 355, 360, 362, 365, 367, 368, 371, 380, 385, 422, 423, 430, 450, 460, 462, 463, 465, 480, 485, 490, 510, 530, 540, 550, 555, 560, 625, 690, 710, 720, 740, 790, 791, 861-865, 870, 871, 890, 950.
*Also complete AO 120 or AO 121. for patent, trademark or copyright cases.

3. **Title and number, if any, of related cases. (See local rule 40.1(g)). If more than one prior related case has been filed in this district please indicate the title and number of the first filed case in this court.**

4. **Has a prior action between the same parties and based on the same claim ever been filed in this court?**
YES ☐ NO ☑

5. **Does the complaint in this case question the constitutionality of an act of congress affecting the public interest? (See 28 USC §2403)**
YES ☐ NO ☑

If so, is the U.S.A. or an officer, agent or employee of the U.S. a party?
YES ☐ NO ☑

6. **Is this case required to be heard and determined by a district court of three judges pursuant to title 28 USC §2284?**
YES ☐ NO ☑

7. **Do all of the parties in this action, excluding governmental agencies of the United States and the Commonwealth of Massachusetts ("governmental agencies"), residing in Massachusetts reside in the same division? - (See Local Rule 40.1(d)).**
YES ☑ NO ☐

A. **If yes, in which division do all of the non-governmental parties reside?**
Eastern Division ☑ Central Division ☐ Western Division ☐

B. **If no, in which division do the majority of the plaintiffs or the only parties, excluding governmental agencies, residing in Massachusetts reside?**
Eastern Division ☐ Central Division ☐ Western Division ☐

8. **If filing a Notice of Removal - are there any motions pending in the state court requiring the attention of this Court? (If yes, submit a separate sheet identifying the motions)**
YES ☐ NO ☑

(PLEASE TYPE OR PRINT)

ATTORNEY'S NAME Matthew Patton
ADDRESS Law Office of Nicholas F. Ortiz, P.C. One Boston Place, Suite 2600, Boston, MA 02108
TELEPHONE NO. (617) 338-9400

AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Massachusetts

Four Women Health Services, LLC

Plaintiff

v.

Abundant Hope Pregnancy Resource Center Inc., d/b/a Attleboro Women's Health Center, Catherine Roman, Nicole Carges, and Darlene Howard

Defendant

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Attleboro Women's Health Center Principal Office
152 Emory St. Unit 4
Attleboro, Massachusetts 02703

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Emily J. Nash
FOLEY HOAG LLP
155 Seaport Boulevard
Boston, MA 02210
(617) 832-1000
enash@foleyhoag.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

.

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Massachusetts

Four Women Health Services, LLC

Plaintiff

v.

Abundant Hope Pregnancy Resource Center Inc., d/b/a Attleboro Women's Health Center, Catherine Roman, Nicole Carges, and Darlene Howard

Defendant

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Catherine Roman
52 ROCKY KNOLL ROAD
NORTH ATTLEBORO, MA 02760

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Emily J. Nash
FOLEY HOAG LLP
155 Seaport Boulevard
Boston, MA 02210
(617) 832-1000
enash@foleyhoag.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

.

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

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AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Massachusetts

Four Women Health Services, LLC

Plaintiff

v.

Abundant Hope Pregnancy Resource Center Inc., d/b/a Attleboro Women's Health Center, Catherine Roman, Nicole Carges, and Darlene Howard

Defendant

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Darlene Howard
21 WILLIAMS STREET
MANSFIELD, MA 02048

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Emily J. Nash
FOLEY HOAG LLP
155 Seaport Boulevard
Boston, MA 02210
(617) 832-1000
enash@foleyhoag.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

.

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Massachusetts

Four Women Health Services, LLC

Plaintiff

v.

Abundant Hope Pregnancy Resource Center Inc., d/b/a Attleboro Women's Health Center, Catherine Roman, Nicole Carges, and Darlene Howard

Defendant

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Nicole Carges
39 RAYMOND TATRO LN
NORTH ATTLEBORO, MA 02760-6265

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Emily J. Nash
FOLEY HOAG LLP
155 Seaport Boulevard
Boston, MA 02210
(617) 832-1000
enash@foleyhoag.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

.

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset