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Ectopic pregnancy remains a leading cause of death in women of childbearing age in the United States [1, 2]. Women at highest risk include those less than 25 years of age and of nonwhite ethnicity [1, 2]. In the Emergency Department (ED), the prompt identi cation of a pregnant woman with an ectopic pregnancy is critical because the sudden rupture of a fallopian tube can lead to hemorrhagic shock [1, 2]. In addition, early diagnosis may allow for non-operative intervention and preservation of fertility. e classic triad for an ectopic pregnancy of abdominal pain, amenorrhea, and vaginal bleeding is only present in about 50% of women with this condition.

A 35-year-old woman with a past medical history of bipolar a ective disorder, anxiety, hemorrhoids, and poly substance abuse presented to the ED with the chief complaint of rectal discomfort. She had two days of di use abdominal pain radiating to the lower back, dyspareunia, dyschezia, and nausea without vomiting. She denied urinary complaints, vaginal discharge, or bleeding. Her last menstrual period was four weeks before. Her physical exam-including pelvic, rectal, and abdominal exam-was unremarkable, and her vital signs were stable. Urinalysis, Complete Blood Count (CBC), Basic Metabolic Panel (BMP), and a vaginal wet prep were all within normal

urine pregnancy test and a